

3) Are **YOU** now getting any treatment for an illness or injury for which another party could be held responsible or could be covered under no-fault, automobile, or liability insurance?

YES ☒

NO ☐

If YES, Date of Illness or Injury: 05-03-1999
M M D D Y Y Y Y

If YES, Insurer Name

ACME NO FAULT INSURANCE

ADDRESS

PO BOX 789

ADDRESS

CITY

METROPOLIS

STATE

NY

ZIP

99998

SECTION C - INFORMATION ABOUT YOUR HUSBAND/WIFE

1) On 7/1/2000, will your husband/wife be working? YES ☐ NO ☒ N/A ☐

(If NO or N/A, STOP, sign bottom of form)

Husband/Wife's Name

FIRST

Middle

Initial

Husband/Wife's Social Security Number

LAST

2) How many employees, including your husband/wife, work for your husband/wife's employer?

Don't know ☐ 20 or more ☐ less than 20 ☐ (If less than 20, STOP, please sign below)

3) Does your husband/wife have group health coverage through his/her employment?

YES ☐ NO ☐

What type of coverage does your husband/wife have under this health plan?

(If NO, STOP, please sign below)

Worker only coverage ☐ Family coverage (husband/wife) ☐

Please provide the name of the employer, and information about the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

CITY

STATE

ZIP

NAME OF HEALTH PLAN

ADDRESS

ADDRESS

CITY

STATE

ZIP

GROUP IDENTIFICATION NUMBER

POLICY NUMBER

Your Signature Is Required

John G. Public

AREA CODE

555

PHONE NUMBER

555

1234